GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF RISK MANAGEMENT

Jed Ross
Chief Risk Officer

Public Sector Workers' Compensation Program

FORM 12 - EMPLOYEE CLAIM FOR PERMANENT DISABILITY COMPENSATION

Use this form to file a claim for a schedule award for permanent disability compensation pursuant to D.C. Code § 1-623.07 with the District of Columbia Public Sector Workers' Compensation Program (PSWCP).

READ INSTRUCTIONS HERE AND ON THE REVERSE SIDE

You MUST complete Sections I and II of this form in their *entirety*. Please submit with this form any necessary attachments. Section III must be completed by a qualified physician with specific training and experience in the use of the most recent edition of the American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment at the time of submission and shall be accompanied by any medical records, report, or evidence that support any rating.

SECTION I. To be completed by Claimant or Representative.

Claimant's Name:		**Representative (if any):**	
Claimant's Full Address (with unit number, zip code):		**Rep.'s Full Address (with unit number, zip code):**	
Claimant's Telephone:		**Rep.'s Telephone:**	
Claimant's E-mail:		**Rep.'s Fax:**	
Claim Number:		**Rep.'s E-mail**	
Date of Birth:		**Date of Injury:**	
Social Security No.:		**Employing Agency:**	
Temporary Indemnity Benefits Started:	(date)	**Temporary Indemnity Benefits Ended:**	(date)

SECTION II. To be completed by Claimant. Circle YES or NO in response to ALL questions in this section.

1. Did you receive temporary disability indemnity compensation for this injury?	YES	NO
2. Has a qualified physician documented that you have reached maximum medical improvement for your disability?	YES	NO
3. Did you suffer the loss of both hands, both arms, both feet, or both legs, or sight in both eyes as a result of your work injury?	YES	NO
4. Have you ever filed a claim for or received permanent disability in the past?	YES	NO
5. Has 181 days or more past since you last received any temporary disability indemnity compensation payment? (If yes, explain good cause for the delay in submitting Form 12 and attach proof.)	YES	NO

CERTIFICATION: I have read this form and I swear or affirm under penalty of perjury under the laws of the District of Columbia that the contents are true and accurate to the best of my knowledge.

Print Name | Signature | Date

➔ ➔ **TURN OVER TO CONTINUE** ➔ ➔

Claimant Name: _____ **Claim No.:** _____

SECTION III. To be completed by Physician. ***Physician's medical report in support of the following opinions must be attached and submitted with this request.***

A. Doctor's Information:

Name: _____ **Practice Name:** _____
Office Address: _____ **Office Phone No.:** _____
_____ **Office Fax No.:** _____

B. Diagnosis or Nature of Disease or Injury

	Enter ICD 10 Code	ICD10 Description
(1)		
(2)		
(3)		
(4)		

C. Maximum Medical Improvement

Has the patient reached Maximum Medical Improvement (MMI)? YES NO

If yes, please provide date patient reached MMI: _____

D. Permanent Impairment

Is there a permanent impairment? YES NO

Schedule loss of use of member of facial disfigurement. (Check and identify impairment rating according to the latest AMA Guidelines and attach separate sheet for additional body parts).

☐ Schedule Loss ☐ Facial Disfigurement

Body Part: _____ Impairment %: _____
Body Part: _____ Impairment %: _____
Body Part: _____ Impairment %: _____

Describe findings and relevant diagnostic test results: _____

_____
_____
_____
_____

(attach medical records, evidence or report in support of findings)

E. Health Care Provider Certification: Signed under penalty of perjury.

_____
Name Signature Specialty Date

Claimant **MUST** file this claim for permanent disability by mail or in person with the PSWCP at the District of Columbia Office of Risk Management between the hours of 8:30 a.m. and 5:00 p.m. at:	**Office of Risk Management** **One Judiciary Square** **441 Fourth Street, N.W., Suite 800 South** **Washington, DC 20001-2714** **Phone: (202) 442-HELP (4357)**